New Jersey Department of Health and Senior Services
Office of Home and Community Services
Adult Day Services Program for
Persons with Alzheimer's Disease or Related Disorders
PO Box 807, Trenton, NJ 08625-0807

DISCHARGE INFORMATION

Name of Agency	
Name of Client	Social Security Number

1. Reason for Client's Discharge from Program *(Check up to 3)* (1) ____ ____

- 00 ☐ Dementia Progression
- 01 ☐ Other Illness/Accident
- 02 ☐ Incontinence
- 03 ☐ Inappropriate Behavior
- 04 ☐ Extended Absence
- 05 ☐ Financial Ineligibility
- 06 ☐ Relocation
- 07 ☐ Client Refusal to Attend
- 08 ☐ Death
- 09 ☐ Other (Specify): _____
- 10 ☐ Family Choice
- 11 ☐ Caregiver Illness/Stress
- 12 ☐ Caregiver Death

Transfer to Other Funding Source:

- 13 ☐ Medicaid
- 14 ☐ CCPED
- 15 ☐ Peer Grouping
- 16 ☐ Respite
- 17 ☐ SSBG
- 18 ☐ Jersey Care
- 19 ☐ JACC
- 20 ☐ CAP

2. Duration of Day Care Attendance (2) ____ ____

- 00 ☐ 0 - 3 Months
- 01 ☐ 3 - 6 Months
- 02 ☐ 6 - 12 Months
- 03 ☐ 1 - 2 Years
- 04 ☐ 2 - 5 Years
- 05 ☐ Over 5 Years
- 06 ☐ Ongoing

3. Client Was Discharged To: (3) ____ ____

- 00 ☐ Home
- 01 ☐ Assisted Living Facility
- 02 ☐ Residential Health Care Facility
- 03 ☐ Long Term Care Facility
- 04 ☐ Acute Care Hospital
- 05 ☐ Not Applicable
- 06 ☐ Other Day Care

4. Last Date Client Received Alzheimer's Adult Day Care Funds (4) ____ / ____ / ____

(Month/Day/Year) _____ / _____ / _____

5. Total Alzheimer's Adult Day Care Funds Billed to DHSS for Client's Care During Current Fiscal Year: (5) $ _____

$ _____

Name of Agency Representative	Title
Signature	Date

CSS-9 (formerly WFS-4)
JUL 04

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